

North Carolina Department of Health and Human Services Division of Health Service Regulation Mental Health Licensure and Certification

2718 Mail Service Center • Raleigh, North Carolina 27699-2718

http://www.ncdhhs.gov/dhsr/

Beverly Eaves Perdue, Governor Lanier M. Cansler, Secretary

Stephanie Alexander, Chief Phone: 919-855-3795 Fax: 919-715-8077

March 20, 2009

Dr. Frank Farrell, Center Director O'Berry Neuro-Medical Treatment Center 400 Old Smithfield Road Goldsboro, North Carolina 27530-8464

Re: Death Review Survey Conducted on 3/13-3/16/09 O'Berry Neuro-Medical Treatment Center, Provider# 34G004, 400 Old Smithfield Road, Goldsboro, North Carolina 27530-8464

Dear Dr. Farrell:

Thank you for the cooperation and courtesy extended during the death review completed 3/16/09.

An immediate jeopardy was identified during the survey. This resulted in the facility being out of compliance with §483.410 Governing Body and Management and §483.420 Client Protections. A plan was developed and implemented to remove the jeopardy on site.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop a Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Condition Level W102 is listed condition level violation i.e. §483.410 Governing Body
- Condition Level W122 is listed condition level violation i.e. §483.420 Client Protections (W149).

Time Frames for Compliance

- A completed Plan of Correction addressing <u>all</u> cited deficiencies must be returned to our office within ten days of receipt of this letter.
- The condition level deficiencies must be corrected within 30 days from the exit date of the survey, which is April 15, 2009. You must request in writing a revisit indicating credible allegation of compliance no later than 30 days following the survey.
- If the facility is not in compliance at the time of the follow-up, a recommendation for termination from the Medicaid program will be made effective within ninety (90) days



Location: 805 Biggs Drive Dorothea Dix Hospital Campus Raleigh, N.C. 27603 An Equal Opportunity / Affirmative Action Employer



from the last date surveyed.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to prevent the problem from occurring again.
- Indicate who will monitor the situation to ensure it will not occur again.
- Indicate how often the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Kimberly McCaskill at (919)855-3805.

Sincerely,

hiabely C. M'Cookill Kimberly C. McCaskill, MSW, QMRP

Facility Survey Consultant I

Enclosures

Cc: dhsrrreports@ncmail.net Carol Donin, State Operated Services Monica Jones, DMA Eastpointe Mental Health, Kenneth Jones Wayne County DSS, Debbie Jones, Director DMH/DD/SAS QM Team Susan Politt, DRNS





DEPARTMENT OF HEALTH AND HUMAN SERVICES

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: 4FMZ11

Facility ID: 955758

If continuation sheet Page 1 of 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 03/19/2009 FORM APPROVED OMB NO. 0938-0391

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FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: 4FMZ11

Facility ID: 955758

If continuation sheet Page 2 of 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	TENDO MENICAL	TREATMENT CENTER			O. N.C. 27530		(VE)
REENER	REUKO-WISIPICALI		·ID		AND OF CORRECT	TION OH D BE	(X5) COMPLETION
X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OPRIATE	DATE
REFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
					a. The Group Home Manager	or the Lead	4/15/09
	Continued From pa	ge 2	W 104		- 1 Tachnician II WIII II	BIKE I COURSE IN	•
,, ., .		1					
1	Interview with man	agement staff on 3/16/09		- 1			
1		n had continued to be a problem meauraged to do unannounced		•			•
				1	review will occur on the individual c		
,	- I	ACTORISE WINE HEREING		1	b. On the days that the Program	Coordinator or	4/15/0 9
	stoff was asked it u	IB2 2Agrent Area decame		1			
.	anywhere, staff sta			l			
ł	2. Client #1 was n	ot provided adequate		1	safety, program implementation a	nd accuracy of	
l	supervision.			1	safety, program implementation as individual check sheets. These I documented on the Group Home Lo		ļ
}		home planner for 5-5 for C-shift			kept at a designated location.	-	
1	Review of a group	6 staff working with 13 clients					4/15/09
. 1	on 3/11/09.			1	c. The Administrator-On-Duty for	the campus will	4713/03
·	-	o c the #120 abasical therany			make rounds in Group Home 5-5 a shift in the evenings, nights, week		
		9 of client #1's physical therapy ment dated 4/17/08 revealed she	1				
	وأحملت سينا وأ	off force to beginning. It illustrates a					1
	1 111						
	t	belt (wider and with Velcro hammock style footrest system	1		the Group Home Log that is kept	at a designated	
	1	wie Himmer review of min	1		location.		
	1 1 . 41	al the factivest was injunited to			4. Custom Adaptations will assess	the status of all	4/15/09
	3	"Low foot "HAWEVET IIKON VI UN					
	l a mandament	reported, [client #1] prefers to sit under her thighs. It is to be noted	1				
	1 -1	Johnir nosilion is millioned than	1		will be made as needed for multivio	Mais Min silde m	`
	this new, more a	propriate wheelchair."	1		their wheelchairs.	•	
			1		5. The program team has alread	y made necessary	4/15/09
		th care personnel registry report yealed client #1 was found	1				
	I managero S	ha had giid down in het wooddaa	1		and staffing to ensure accommand	dress the Program	a
	1 the mathait	man actors her hear a	1				
	pronounced dead	l at a local hospital on 3/11/09.					
	1 -	09 of a statement dated 3/11/09					
1	Review on 3/13/	AA AT B SIMMATTER THE	1		5. This will be completed and Program Coordinator and Special P in Group Home 5-5 no later than Ap	CHOOL COMMISSION	
		•	1		in Group Mome 3-3 no take man 14		
		•			m Group Fibrac 5-5 its data 12.		nuation sheet

FORM CMS-2367 (02-99) Provious Versions Obsolete

Event ID: 4FMZi 1

Facility ID: 955758

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

TENTER!	MENT OF HEALT S FOR MEDICAR	WIELICALD DER VILLER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SUR COMPLETI	ED
ND PLAN	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1	BUILDING	03/16	
		34G004	B.	WING DRESS, CITY, STATE, ZIP CODE		
AME OF I	PROVIDER OR SUPPLIE	R		MITHFIELD RD	•	
	- TOTAL	TREATMENT CENTER		NO. NC 27530		- Aren
BERRY			ID	PROVIDER'S PLAN OF CORRES		(X5) COMPLETION
X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES (MUST BE FRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ALTISOTHER APP CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
W 104	Continued From pa		W 104	6. Staff of Group Home 5-5 will rec April 15, 2009 on the following win maintained by Staff Development:	eive training by th signed maters	4/15/09
,	Further review of the went to the dining	ed she took client #1 to her imately 5:40pm on 3/11/09. his statement revealed she then room and assisted with feeding her review of the statement		a. Best practices in communi information when transferring clien from one staff to another will be in Special Projects Coordinator.	cating essential t responsibilities 1-serviced by the	4/15/09
	revealed, "When the we usually all chec With client #1 we so automatic we all	the chems are in that except the every 5-10 minutes (sic). all know she likes to slide down I know to keep checking on her."		b. "How to Be a Working Supervisor conducted by the Center Director or d	r" training will be lesignee.	4/15/09
	stated she was bet administrator (CA investigation on 3 CA's office and a #1. Staff told her staff #1 walked at and called her nat client #1. shumped around her neck a #1's eyes were of #1 called for assi #15. Staff #15 wisual supervision she yelled for asse client #1 down oundid her seathed and started cardi. During interview would check on down in her whe down this far be					
	facility on 3/16/	nurses and medical staff at the 09 revealed staff #10 called for le blue was called, CPR outs to resuscitate client #1. The rived and client #1 was				

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: 4FMZ11

Facility ID: 955758

If continuation sheet Page 4 of 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03/16/2009 B. WING 34G694 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 400 OLD SMITHFIELD RD O'BERRY NEURO-MEDICAL TREATMENT CENTER GOLDSBORO, NC 27530 PROVIDER'S PLAN OF CORRECTION COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG W 104 Continued From Page 4 W 104 Transported to a local hospital where she was pronounced dead at 7:43pm. Review of a supervision inservice dated 2/27/09-3/10/09 revealed client #1 was to be checked every 15 minutes when she was away from her group. Observations at the facility on 3/13/09 and at 3/16/09 revealed staff had implemented a system of documenting when clients in group home 5-5 left their 2 groups (Group A and Group B) to go to other areas on the home. Per staff interview on 3/113/09 fifteen minute checks were not being documented prior to client #1's death. Following the death, the facility implemented the fifteen minute supervision checksheets. Review of these supervision checksheets on 3/13/09 and on 3/16/09 revealed staff were completing the sheets anytime a client in group home 5-5 left group A or group B to ensure staff were certain of client's exact locations in the unit at all times. Interviews with staff working in group home 5-5 on 3/13/09 and on 3/16/09 revealed some staff were not certain exactly how to implement the checksheets. Some staff thought they were only to be implemented at night, some staff thought they had to be implemented all the time and some staff was not certain this system was in effect. Interview with facility management staff on 3/16/09 revealed following client #1's death in group home 5-5 that the only system management put in place to ensure adequate

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supervision was the implementation of the fifteen minute checksheets. Facility management staff

Event ID: 4FMZ11

Facility ID: 955758

If continuation sheet Page 5 of 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

EPAKIN	END MEDICAR	E & MEDICAID SERVICES		DATE SURV	EY
TAINTIN ATTAIT	OF TREECHENCIES	(XI) PROVIDER/SUPPLIER/CLIA	1) MULTIPLE COMPLETE	D
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:		BUILDING C	enne.
		34G004		WING	
	on et wer le	b	STREET AD	DRESS, CITY, STATE, ZIP CODE	
AME OF P	ROVIDER OR SUPPLIE		AND OLD S	MITHFIELD RID	
	MEDICAT	TREATMENT CENTER		DRO, NC 27530	
BERRY				THE CHARLES BY AN OF CORRECTION	(X5) COMPLETION
X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID PREFIX		DATE
REFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
W 104	Continued From p	age 5	W 104		
		i i			
. 1	Acknowledged the	re was confusion regarding		The facility will ensure that individuals in Group	4/15/09
W 122	483,420 CLIENT	PROTECTIONS	W 122	The facility will ensure that universalish in Graph Home 5-5 will be safe from neglect by the following:	٠
W 122	•				4/15/09
-	The facility must	ensure that specific client	·	1. During waking hours, staff will check on individuals every 15 minutes who have time to	•
	protections requir	ements are met.		individuals every 15 minutes with the section of the section the section staff and document these checks	
				on the individual supervision check sheet.	
					4/15/09
•	This CONDITION	I is not met as evidenced by:		2. At night, during hours of sleep staff will check on individuals every 30 minutes. Documentation of these	.,
	أدره الأمكاء سمواوي ويسا	to develop and implement		checks will not be required.	
	procedures that pr	chibited the neglect of a client		- 1 · · · · · · · · · · · · · · · · · ·	4 64 57000
	(W149).			3. A deviation from this model requires the Team's	4/15/09
		m + -Estraca gretamic		review with documentation by the Program Coordinator of the individual's supervision	
• • •	The cumulative e	ffect of these systemic in the facility's failure to	1	Continuator of the Power Centered Plan. Theses	
	practices resulted	y mandated services of client			
	provide statutority	clients.			
	protections to 12				
•		•		individuals according to the agreed upon requirements and document these checks on the individual supervision check sheet as required.	
		•		See W149 for detailed actions.	
•		PERMIT OF OF CHILDREN	W 149	•	4/15/09
W 149	1	FF TREATMENT OF CLIENTS	"-"	1. Staff of Group Home 5-5 will receive training by	.,,,,,,,
	The facility must d	evelop and implement written		1. Staff of Group Fichie 3-3 with signed rosters April 15, 2009 on the following with signed rosters maintained by Staff Development:	
	i natione and proces	hires that promibit unisucumous		•	
	neglect or abuse of	the chent		a. The Cluster Administrator will ensure all staff have	4/15/09
	This STANDARI) is not met as evidenced by:	1	and the mornoranda by Secretary Lamer Causica	1
	l m	HOME TROOMS SEVIEW HING		"The Zero Tolerance for Client Abuse /Neglect/ Exploitation for Failure to Comply With Mandatory	
	I was dealer	whatre with simil, we identy	. 1	The Address of the Property of the Control of the C	-
	neglected to prov	ide adequate supervision to ensure ats who resided in unit 5-5 after		"Mandatory Reporting" dated February 24, 2009	
	and had been it	Journal I MADRIER I INCOME WITHOUT		1	4/15/09
	conducted within	the last three months. The	1	b. The Special Projects Coordinator will train all staff	
	findings include:			1 4 (c) 4 compations in property Parellina IIII Visitation	I .
) "			when transferring client responsibilities from one staff	1
ĺ	1. Clients in 5-5	were not provided adequate		to mother.	
1	supervision.	v included pertinent		Facility ID: 955758 If continu	uation sheet Page

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: 4FMZ11

Facility ID: 955758

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (XI) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03/16/2009 B. WING 34G004 STRHET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 400 OLD SMITHFIELD RD O'BERRY NEURO-MEDICAL TREATMENT CENTER GOLDSBORO, NC 27530 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PRICITY TAG DEFICIENCY) TAG W 149 Continued From page 6 4/15/09 2. The supervision requirements for each individual in W 149 Group Home 5-5 will be assessed by the team and any Investigations involving supervision of clients changes resulting from the assessment will be residing in group home 5-5: documented in the individual Person Centered Plan by the Program Coordinator no later than April 15, 2009. a. On 3/16/09 a facility investigation, dated 4/15/09 3. During waking hours when individuals have 2/12/09, was reviewed. According to the time to themselves supervision checks are required. investigation a teacher for group home 5-5 walked into an activity room and found clients Rate and type of monitoring will be determined by unattended. One of the clients required constant the Habilitation Team to ensure safety of the individual according to individual supervision visual supervision. Neglect was substantiated and staff was re-inserviced on supervision levels requirements. of clients in 5-5. The investigation noted a 4/15/09 concern that staff was extending supervision of The Group Home Manager or the Lead the activity room to the hallway on one side and Developmental Technician II will make rounds shift to ensure client the bedroom area on the other side. throughout each accountability, supervision and safety, program An in-service (signed by staff 2/27/09 through implementation and to monitor and document the 3/10/09) regarding supervision for group home completion of check sheets. Documentation of this 5-5 was reviewed on 3/16/09. Document review review will occur on the individual Check Sheet. revealed the in-service took place prior to 4/15/09 3/11/09, when the incident with client #1 b. On the days that the Program Coordinator or occurred. Staff on all three shifts attended this Chuster Administrator are present rounds will be in-service. According to the in-service, "Every made to ensure client accountability, supervision, safety, program implementation and accuracy of fifteen minute checks only apply to personal leisure periods such as when an individual is not individual Check Sheets. These reviews will be in a group setting such as their bedroom. Do not documented on the Group Home Log that is always leave an individual or the group alone in the kept at a designated location. training (living) environment at any 4/15/09 time...Monitor [Client #1] from a visual c. The Administrator-On-Duty for the campus will make rounds in Group Home 5-5 at least once per shift distance at least every fifteen minutes if she in the evenings, nights, weekends and holidays to chooses to have time alone...." ensure client accountability, supervision, safety, program implementation and accuracy of individual b. On 3/16/09 another facility investigation, Check Sheets. These reviews will be documented on dated 2/18/09, was reviewed. According to the the Group Home Log that is kept at a designated investigation a client was without 1:1 attention per her plan. The client was in a recreation area with 4 other clients and only one staff. 2. Client #1 was not provided adequate supervision.

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Event ID: 4FMZ11

Facility ID: 955758

If continuation sheet Page 7 of 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES

A THE PARTY AND A STATE	T OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	e) Multiple construction Building	COMPLETE	
		34G004		WING	03/16/	2009
·		775	STREET AD	DRESS, CITY, STATE, ZIP CODE		
VAME OF	PROVIDER OR SUPPLIE		ADD OLD S	SMITHFIELD RD		·
		TREATMENT CENTER		ORO, NC 27535		CVE)
O'BERRY	NEUKO-MEDICAL		ID	THE PROPERTY AND OR CORRE	CTION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		DATE
W 149	Continued From p	having planner for 5-5 for C-	W 149	4. Custom Adaptations will assess wheelchairs and check the appropria for each individual in Group Home will be made as needed for individual	5.5 Adentations	4/15/09
	shift revealed ther clients on 3/11/09 Review on 3/13/0 therapy functional revealed she had wheelchair. It into a half inch cushid (wider and with hammock style formests. Further revealed the foot placing of her formatted and sent and se	6 Mete o start Morkrise and		their wheelchairs. 5. The program team has already adjustments with client groupings, and staffing to ensure accountable the team will continue to review Program Content schedule to treatment and appropriate require each client in Group Home 5-5 completed and in-serviced by Coordinator and Special Project Group Home 5-5 no later than April 15, 2009 on the follow	made necessary activity locations ility and safety- and address the ensure active d supervision of This will be the Program Coordinator in il 15, 2009.	4/15/09 - 4/15/09
	noted that overal improved with the wheelchair." Review of a head	Il wheelchair position is nis new, more appropriate Ith care personnel registry report wealed client #1 was found		a. Best practices in commu information when transferring clie from one staff to another will be Special Projects Coordinator.	nicating essential	4/15/09
	unresponsive. S wheelchair and She was pronou 3/11/09.	the had slid down in ner the seatbelt was across her neck. need dead at a local hospital on		b. "How to Be a Working Super be conducted by the Center Direc	visor" training will tor or designee.	4/15/09
	by staff #14 rev bedroom at app Further review "When the clie usually check of	/09 of a statement dated 3/11/09 realed she took client #1 to her roximately 5:40pm on 3/11/09. of this statement revealed, into are in their bedrooms we very 5-10 minutes(sic). With know she likes to slide down so all know to keep checking on her.				
	During intervi	ew with staff #1 on 3/13/09, she		M211 Facility ID: 955758	H conti	nuation sheet Pa
			Fueint TO: 4F	MZ11 Paguny ID. 935730		

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Event ID: 4FMZ11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 03/19/2009 FORM APPROVED OMB NO. 0938-0391

CHECKITE	DS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SUR COMPLET	VEY ED
	ENT OF DEFICIENCIES IN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	03/16	/2009
·.		34G004	B. WIN	SS, CITY, STATE, ZIP CODE	<u> </u>	
I	F PROVIDER OR SUPPLIE	} ,	400 OLD SMI	THFIELD RD		
O'BER	RY NEURO-MEDICAI	TREATMENT CENTER	GOLDSBORG	PROVIDER'S PLAN OF CORRECT PROVIDER'S PLAN OF CORRECT PROVIDER'S PLAN OF CORRECT PROVIDER SECONDARY ACCIONS SECONDARY ACCIONATE AC	TION ULD BE	(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR L	ATEMENT OF DETICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION SEC CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
W 149			W 149			
	administrator (CA) investigation on 3/ CA's office and as #1. Staff told her	ng interviewed by the cluster in conjunction with an 11/09. Staff#1 came out of the ked the other staff about client client#1 had not eaten yet, so ross the hallway to her bedroom				
	and called client #1 sh found client #1 sh seathelt around he stated client #1's pale. Staff #1 cal to staff #15. Staf	amped in her chair with her a neck around 6:45pm, She eyes were open and her lips were led for assistance. Staff #1 called f#15 was with a group that				
	group, so she yet she slid client #1 bedroom and und into the room an resuscitation (CI staff #1 stated th	pervision and count not led for assistance. Staff #1 stated down out of her chair in her lid her seathelt and staff #10 came i started cardio-pulmonary R). During interview on 3/13/09, by would check on client #1 lid slide down in her wheelchair but d down this far before.				
	Phone interview revealed on 3/1 meeting with the After the meeting on the growth of th	w on 3/16/09 with staff #15 1/09 she was involved in a ne CA involving an investigation. ng, staff #15 stated she would oup while staff #1 was being				
	said staff #1 the interviewed. To office she wal asked if client reported state when everythe calling for he	When staff #1 came out of the ked out into the dining room and #1 had eaten yet. Staff #15 1#1 said 'come here' and "that's ing started." Staff #15 reported in and stated "a lot of people when the did not know				
		in her room and stated staff shoulif they put a client in their room.	ld Sant To ARM	711 Facility ID: 955758	Ис	ontinuation sheet Page 9 of

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Bvent ID: 4FMZ11

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPART	MENT OF HEAL I	& MEDICAID SERVICES		X2) MULTIPLE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY TED
THE A PRIVATE ATTAIL	TOF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		c
IND PLAN		. 34G004		B. WING	03/1	6/2009
	ROVIDER OR SUPPLI		(ADDRESS, CITY, STATE, ZIP CODE		
				SMITHFIELD RD		
YBERRY	NEURO-MEDICAL	TREATMENT CENTER		BORO, NC 27530 PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST HE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	THE PROPERTY OF THE PROPERTY O		DATE
			W 149			
W 149	Continued From p				•	•
-	Interview with nu	rses and medical staff at the revealed staff #10 called for				
	continued in effor	ts to resuscione ending	1	·		1
	transported to a le pronounced dead	neal mospital wing come it as			•	
	had witnessed cl	on 3/13/09, staff #17 stated she ient #1 sliding down in her laff would reposition her before oper stomach. We reposition her 'yelling'.	1			
	Review of staff; revealed, "[Cliento sit in a chair to bed with the TV every 15 minute	#13's statement dated 3/12/09 of #1's] normal routine would be watching television or lay on her on. She would be checked s by the person who put her in he who was assigned to her or heard her scream who check to				·
	Review of supe 2/27/09-3/10/0 checked every from her group	rvision requirements dated 9 revealed client #1 was to be 15 minutes when she was away				
	of documenting left their 2 ground to other areas on 3/13/09 fiff documented p	t the facility on 3/13/09 and at ed staff had implemented a syster g when clients in group home 5-; ups (Group A and Group B) to g of the home. Per staff interview een minute checks were not bein rior to client #1's death, the facility implemented nute supervision checksheets.	0			
		1 Waring Charlete	Event IC): 4FMZ11 Facility ID: 955758	. If	continuation sheet Page 10

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 03/19/2009 FORM APPROVED OMB NO. 0938-0391

A TA 677	CATE OF HEALT	TH AND HUMAN SERVICES B MEDICAID SERVICES					(X3) DATE	STRVE	Ÿ	
DEPART	WENT OF THE AR	E & MEDICAID SERVICES [(X1) PROVIDER/SUPPLIER/CLIA		(2) MIJI.	TPLE CONSTRUCT	ION	COM	PLETED	-	
CENTER	S FOR MEDICAL	(X1) PROVIDER/SUPPLIER/CLIA	1	_		•	ľ		Į.	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSOFT INTEREST IDENTIFICATION NUMBER:	A	BUILDI	NG		1 .	C 03/16/20	on.	
ANDTLAN	0. 002		١.,	. WING				13/10/20		
		34G004	1.5). WILLIO		CODE			1	
			STREET A	DORESS,	CITY, STATE, ZIP	CODE				
NAME OF	PROVIDER OR SUPPLI	ER			FIELD RD				1	
			400 OLD	1 3917EE A.A.	- AEF70					
owners.	V NETIRO-MEDICAL	L TREATMENT CENTER	GOLDS	BORO, P	IC 27530	PLAN OF CORRE	CTION		(X5) COMPLETION	
O.BERCE	I MEGRA	THE PROPERTY OF THE PROPERTY O	ID ID		PROVIDER:	CTIVE ACTION SH	OULD BE	١,	DATE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX	1			ROPRIALE	- 1		l
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED IT ALL INCOME. LSC IDENTIFYING INFORMATION)	TAG	1	1	DEFICIENCY)		- 1		ĺ
TAG	REGULATORION			ł						l
			777 1 40		•			1		
	Continued From	page 10	W 149					1		1
W149				1	•			ł		1
	Davionic of these	supervision checksheets on	1	1			•	1	•	1
1	3/13/00 and on 3	/16/09 revealed stuff were						1		
1	completing the si	heets anytime a client in 5-5 left		1				l		
	moun A or groun	B to ensure staff were certain		ļ	•			1	•	
1	of the client's ex	act location in the unit at all	1	- 1		•		1		
1	times.			1		•				
		home on	1	1	•.				•	
	Interviews with s	taff working in the group home on						1		
			1	1				Į		
1	not certain exact	ly how to implement the me staff thought they were only to		[1	•	1
1	checksheets. So	me statt unbegat the state they		1						1
1			\	1						1
1	had to be implead	his system was in effect.	1			•				1
			ŀ	1						ì
Ì	Interview with f	acility management staff on								-
1	3/16/09 revealed	i following client #1's death in	、 1	1						1
	l	that the fails storem but a	'	l						[
	ensure adequate	Supervision was an	l l						1	1
1	implementation	of the inner inner was	8	l					1.	
ľ	Facility manage	ding the use of the checksheets.		1						- 1
				1						
1	Om 2/17/00 the	e facility's policy, Reporting of		1						- 1
				- 1					1	- 1
1									1	1
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	maintain the I	nental or physical health of a		1		•				1
	client", includ	nental or physical heates or requiring "Leaving a client who require them at risk."	E2	1					1	1
	assistance uns	supervised, placing them at risk."	- 1	-			•			1
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	The Team on	-site identified a situation of	ne	.			-		1	- 1
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Ì	putting them	at increased tisk. The analy on 3/16/09).							1
	notified of the	at increased list. the immediate jeopardy on 3/16/09 was able to develop a plan on-site.	e to							
1	The facility	was adie to develop a part				ncility ID: 955758		If cont	inuntion sheet Pag	e 11 of
- 1				* 4FM7.11	F	neurly i.v. 333730				

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OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (XI) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 03/16/2009 B. WING 34G004 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 400 OLD SMITHFIELD RD O'BERRY NEURO-MEDICAL TREATMENT CENTER GOLDSBORO, NC 27530 PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH CORRECTIVE ACTION SHOULD BE D SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG W 149 Continued From page 11 W 149 Remove the jeopardy to the clients which included the following: "Plan of Supervision and Monitoring to Ensure Safety in Group Home V-5" "Immediately beginning today we will begin to meet individually with each staff who works in V-5 and re-inservice them on the supervision requirements for the individuals who live there and the staff's requirements to document this monitoring: We will insure that each staff understands that the following changes are being mađe: 1. Monitoring checks of 15 minute intervals for all individuals in the home will begin immediately and this monitoring will be documented on the form that has been developed. 2. This monitoring will be done 24 hours a day 7 days a week until Executive management team determines it may be lessened. This will be no less than 30 days. 3. A Health Care Supervisor I or other management personnel will be present at all times on V-5. This manager will be responsible for continuously floating to ensure that the staff is in place are providing care and active treatment and are documenting the 15 minute checks. We are immediately placing (name of manager) there on C shift as the manager and moving the C shift health care manager to A shift. These managers will notate on the 15 minute checksheet that they have reviewed the monitoring information. If they find any problems with the log they will immediately contact the acting PC and CA and begin an

administrative review that may lead to disciplinar FORM CMS-2567 (02-99) Previous Versions Obsolete

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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THE RESERVE AND ADDRESS.	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENCE IDENTIFICATION NUMBER:		A. BUILI	ING	· · · · · · · · · · · · · · · · · · ·		03/16/	, M000	1
AND PLAN	AL COMMON		١.	· wind			.	0.3/10/	120rd 7	1
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W 149	Continued From)age 12		1		•		•	1	1
	action.	· .	•	١					1	1
	A DOLLAR horse	assigned to V-5 and is			•					
	4. APC nas occa	g their office to this area and an		1						ł
	physically movin	eady been re-assigned and been		1					1	
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	Will illustrate a rog	nonitoring. Should any							1	1
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	problems to least	y Director and the Center			_					- 1
	Director and an	administrative review will be							}	
1	initiated.			1					1	- 1
	1 "		1	1						·
	5 Daily once it	the morning and once in the	1	1					1	
1			1	- 1		•				-
1	Coordinator wil	l personally come to V-5 and	1	1						1
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			1	- 1				•		- 4
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1	documentation	is in place. They will send daily	1	1					1	1
1	reports to the a	ting CA. If they should see any	1	1					1	1
-	problems they	will immediately report them to	. 1	1					[-
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1	administrative	review will be initiated.	1	1						ŀ
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1 .	6. During the t	hight on the A shift the AOD will	1	1					, ·	
		ilding hourly to review the and also initial the checksheet.	1						\	
	documentation	blems be notified they will	1						1	
1	Should any late	all the CA to report the issue found.							1	
1	minetimetry Co	*	.						1	
1	7 All team II	nembers who work in this area wil	u			٠			1 .	
1							•	•		
1									1.	
1	individuals th	ere. This will be completed in on	10							
- 1	week."	•	1	•						
1	1	Tw	. 1		1			,		12
1	This olan wa	s reviewed by the team on-site. In	<u> </u>		<u> </u>	Facility ID: 9557:	18	1f co	ntinuation sheet Pr	1ge 15 (
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ENTER	S FOR MEDICAR. TOF DEFICIENCIES OF CORRECTION	H AND HUMAN SERVIC E & MEDICAID SERVIC (XI) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMB	IA (X ER: A	2) MULTIPLE CONSTRUCTION BUILDING WING	· ·	(X3) DATE SURVEY COMPLETED C 03/16/2009	
		34G004					
	PROVIDER OR SUPPLIE		400 OLD	DDRESS, CITY, STATE, ZIP CODE SMITHFIELD RD ORO, NC 27530	•		
X4) ID REFIX TAG	SUMMARY STA	RO-MEDICAL TREATMENT CENTER GOLDSBORO, NC 27530 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF DEFICE SUMMARY STATEMENT OF DEFICE SUMMARY STATEMENT OF SUMMARY STATEMENT OF SUMMARY STATEMENT OF SUMARY STATEMENT OF SUMARY STATEMENT OF SUMARY STATEMENT OF SUMARY STATEMENT				(X5) COMPLETION DATE	
W 149	Continued From p		W 149				
	Steps 1 and 2, the removed to the cli	mediate implementation of immediate jeopardy was ents residing in unit 5-5. The the center director and the the center on 3/16/09.	nis -		· .		
		f Steps 3 through 7 will be follow-up visit within 30 da	nys.				
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		·					

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